STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	454126	A. BUILDING _____ B. WING _____	10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DALLAS BEHAVIORAL HEALTHCARE HOSPITAL LLC	800 KIRNWOOD DRIVE DE SOTO, TX 75115

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation (s) will be referred to the Dallas Regional Office (RO) for referral to the office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An on-site unannounced full survey was conducted from 10/15/2018, to determine the hospital's compliance with the Medicare Conditions of Participation set forth at 42 CFR Part 482. An entrance conference was held in a conference room with the administrative staff members. The purpose and process of the survey was explained and an opportunity was given for questions and discussion. An exit conference was held on 10/19/2018 with administrative staff members. The preliminary findings of the survey were explained. An opportunity was provided for the facility to provide evidence of compliance with those requirements for which non-compliance had been found during the survey.	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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A 000	Continued From page 1 The deficient practices were identified under the following Conditions of Participation and were determined to pose Immediate Jeopardy to patient health and safety, and placed all patients at risk for the likelihood of harm, serious injury, and possibly subsequent death. CFR 482.13 Patient Rights The Immediate Jeopardy was not abated and was determined to be ongoing at the time of exit. The facility was found to be out of compliance with the following Conditions of Participation: CFR 482.12 Governing Body CFR 482.13 Patient Rights CFR 482.21 QAPI	A 000		
A 043	GOVERNING BODY CFR(s): 482.12 There must be an effective governing body that is legally responsible for the conduct of the hospital. If a hospital does not have an organized governing body, the persons legally responsible for the conduct of the hospital must carry out the functions specified in this part that pertain to the governing body ... This CONDITION is not met as evidenced by: Based on review of records and interview, the Governing Body (GB) failed to: A) ensure the Medical Staff defined in the medical staff bylaws the appointment and practice of 9 out of 9 non-physician practitioners . Refer to Tag A0045	A 043		

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A 043	Continued From page 2	A 043		

B) monitor its contracted services through Quality Assurance Performance Improvement (QAPI) and through the Governing Body (GB).

Refer to Tag A0083

C) ensure the contract for Linen Services was current and covered continued services.

Refer to Tag A0084

Based on review of records and interview, the facility failed to:

D)
1) protect the patients from sexual predators, and to identify predators and victims of sexual abuse in 2 (45 and 33) of 2 charts reviewed.

2) provide timely staff education, an approved policy and procedure, or any plan of monitoring of room assignments for patient safety.

3) provide a plan of quality assurance performance improvement (QAPI) for sustainability of education of staff, data collection through chart audits, or tracking method to prevent a patient from being a victim of sexual abuse.

4) ensure medications given in a psychiatric emergency were ordered, administered, and

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A 043	Continued From page 3	A 043		

monitored to make sure they were appropriate and safe in 6 out of 6 (Patient #21, #22, #27, #28, #20, and #33) patients reviewed.

5) ensure, when medications were ordered by physicians, they were documented by the physicians with the required elements per the Texas Administrative Code.

6) ensure Medical Staff managed the process of ensuring safety and appropriateness of medication administrations in a behavioral emergency through the peer review process per hospital policy. Medications given in a behavioral emergency were not analyzed and evaluated through hospital processes or programs to ensure safety and appropriate usage. Psychotropic medications (medication capable of affecting the mind, emotions, and behavior) were observed to be given for staff convenience in 1 (Patient #33) out of 2 patients (Patient #32 and #33) for emergency behavioral medication administrations.

Medications given without proper oversight and review of the Medical Staff and hospital administration, and given for staff convenience, have the potential for these medications to be abused by staff causing psychological harm to patients, physical harm during forced administration of medications, or for patients to become over sedated, resulting in the likelihood for death.

7) develop policies and procedures that prevent the exchange of patient care information via text messaging unless it is on a secured platform. Patient care decisions were made via unsecured text messaging by limiting patient identifying

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A 043	Continued From page 4	A 043		

information. Without the use of appropriate patient identifiers, the potential existed for errors in patient care decisions.

8) provide a safe setting for the psychiatric patients. Ligature risks were observed and identified during the tour of the hospital on the afternoon of 10/15/2018 accompanied by the administrative staff and on the afternoon of 10/16/2018 accompanied by the environmental staff. The presence of ligature risks in the physical environment of a psychiatric patient, including any setting where psychiatric patients may be present, even for a short period of time, compromises their right to receive care in a safe setting.

These deficient practices were identified under this Conditions of Participation and were determined to pose Immediate Jeopardy to patient health and safety, and placed all patients at risk for the likelihood of harm, serious injury, and possibly subsequent death.

Refer to TAG A0144

E) 1) protect Patient #1 and #49 from further harm by investigating to see if the children had been injured and needed further examination, if the physician had all the information to make an appropriate plan of care and potential examination, that the patient received appropriate counseling concerning the sexual abuse, and if the patients' CPS worker or legal representative was informed of the full extent of the sexual abuse that had occurred in the facility in 2 of 2 (Patient #1 and Patient #49) charts reviewed.

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A 043	Continued From page 5 2) identify events and occurrences of sexual abuse by investigating, monitoring, tracking, and analyzing all incident reports to protect all patients from sexual abuse and harm. Refer to TAG A0145 F) 1) assess data to set priorities for performance improvement (to include annual Nurse Staffing Plan) 2) consider the incidence, prevalence, and severity of problems or to focus on problem prone areas that affected health outcomes, patient safety, and quality of care. 3) to measure any successful performance improvements or track performance to ensure that improvements are sustained. 4) to ensure an annual evaluation from the Nursing Advisory Committee was submitted to Quality Assurance Performance Improvement (QAPI) to determine adequacy of the nursing staffing plan. Refer to TAG A0283 G) 1) ensure ongoing data analysis, tracking, and measurable performance improvements that identified and reduced medical errors, adverse events, and gave a clear expectation for patient safety. 2) ensure that the hospital had an active	A 043		

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A 043	Continued From page 6 functioning safety program reporting data and performance improvement. Refer to TAG A0286	A 043		
A 045	MEDICAL STAFF CFR(s): 482.12(a)(1) [The governing body must] determine, in accordance with State law, which categories of practitioners are eligible candidates for appointment to the medical staff. This STANDARD is not met as evidenced by: Based on review of records and interview, the Governing Body failed to ensure the Medical Staff defined in the medical staff bylaws the appointment and practice of 9 out of 9 non-physician practitioners . Review of the facility's credentialing roster revealed there were 9 non-physician practitioners who were practicing in the facility. There were 5 Nurse Practitioners, 1 Physician Assistant, and 3 Doctors of Psychology. Review of credentialing files revealed, the 9 non-physician practitioners were credentialed by the facility in the same manner as physicians. Review of the medical bylaws revealed there was no mention of credentialing process, appointment, or direction for the practice of non-physician practitioners. An interview was conducted on 10/17/18 with	A 045		

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A 045	Continued From page 7 Staff #1. Staff #1 was asked to look through the bylaws and confirm there was no mention of credentialing process, appointment, or direction for the practice of non-physician practitioners in this facility. Staff #1 reported she could not find anything and would make sure that was corrected. An interview was conducted with Staff #35 (Medical Director) on 10/19/18. Staff #35 reported that he was not aware that the bylaws did not contain any mention of credentialing process, appointment, or direction for the practice of non-physician practitioners in the facility.	A 045		
A 083	CONTRACTED SERVICES CFR(s): 482.12(e) The governing body must be responsible for services furnished in the hospital whether or not they are furnished under contracts. The governing body must ensure that a contractor of services (including one for shared services and joint ventures) furnishes services that permit the hospital to comply with all applicable conditions of participation and standards for the contracted services. This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to monitor its contracted services through Quality Assurance Performance Improvement (QAPI) and through the Governing Body (GB). Review of the GB and QAPI meeting minutes for 2017 and 2018 revealed, there was no	A 083		

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A 083	Continued From page 8 documentation that the contracted services had been addressed. An interview was conducted with Staff #1, Staff #3, and Staff #4 on 10/19/18. Staff # 4 reported that he did not take care of the contracts but they had discussed them. Staff #4 was unable to show any documented evidence that contracts were discussed and updated through QAPI. Staff #4 stated, " I don't handle the contracts." Staff #1 stated, " I know we talk about them in our meetings." Staff # 1 was not able to provide documentation of reviewed contracted services through GB. Staff #3 reported that the past Chief Operating Officer was in charge of maintaining and reviewing contracted services. Staff #3 stated that the previous employee was still working for the system but was no longer at that facility. Staff #3 reported that he was, "effective immediately," turning that responsibility over to staff #4. There was no further evidence provided.	A 083		
A 084	CONTRACTED SERVICES CFR(s): 482.12(e)(1) The governing body must ensure that the services performed under a contract are provided in a safe and effective manner. This STANDARD is not met as evidenced by: Based on observation, record review, and interviews, the facility failed to ensure the contract for Linen Services was current and covered	A 084		

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A 084	Continued From page 9	A 084		

continued services.

Findings included:

During a tour of the1st floor (1 out of 2 patient care floors) on 10/16/2018 with Staff #7 and Staff #14 at 10:10AM, clean linen was observed being transported into the facility. Staff #7 was interviewed during the tour and stated, "They deliver and pick up clean and dirty linen on Tuesday and Friday."

Review of the list of contracts showed the current contract termed/cancelled on 8/31/2018. Review of the contract service agreement letter dated July 25, 2018, also revealed the current contract termed/cancelled on 8/30/2018. The letter stated:

"To Whom It May Concern:

Thank you very much for the services you have provided our facility. At this time, we will be moving in a different direction with our linen services. This letter will serve as our 30-day notification of termination of services, termination date to be Aug 30, 2018.

Please feel free to contact me if any additional information is needed."

An interview was conducted on 10/16/2018 at 11:40AM and Staff #3 stated, "We are still under contract with them." No new contract was provided.

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A 115	Continued From page 10	A 115		
A 115	PATIENT RIGHTS CFR(s): 482.13 A hospital must protect and promote each patient's rights. This CONDITION is not met as evidenced by: Based on review of records and interview, the facility failed to: 1) A) protect the patients from sexual predators and to identify predators and victims of sexual abuse in 2 (45 and 33) of 2 charts reviewed. B) provide timely staff education, an approved policy and procedure, or any plan of monitoring of room assignments for patient safety. C) provide a plan of quality assurance performance improvement (QAPI) for sustainability of education of staff, data collection through chart audits, or tracking method to prevent a patient from being a victim of sexual abuse. D) ensure medications given in a psychiatric emergency were ordered, administered, and monitored to make sure the medications were appropriate and safe in 6 out of 6 (Patient #21, #22, #27, #28, #20, and #33) patients reviewed. E) ensure, when medications were ordered by physicians, they were documented by the physicians with the required elements.	A 115		

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A 115	Continued From page 11	A 115		

F) ensure Medical Staff managed the process of ensuring safety and appropriateness of medication administrations in a behavioral emergency through the peer review process per hospital policy. Medications given in a behavioral emergency were not analyzed and evaluated through hospital processes or programs to ensure safety and appropriate usage. Psychotropic medications (medication capable of affecting the mind, emotions, and behavior) were observed to be given for staff convenience in 1 (Patient #33) out of 2 patients (Patient #32 and #33) for emergency behavioral medication administrations.

Medications given without proper oversight and review of the Medical Staff and hospital administration, and given for staff convenience, have the potential for these medications to be abused by staff causing psychological harm to patients, physical harm during forced administration of medications, or for patients to become over sedated, resulting in the likelihood of death.

G) develop policies and procedures that prevent the exchange of patient care information via text messaging unless it is on a secured platform. Patient care decisions were made via unsecured text messaging by limiting patient identifying information. Without the use of appropriate patient identifiers, the is a likelihood for errors in patient care decisions.

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A 115	Continued From page 12 H) provide a safe setting for the psychiatric patients. Ligature risks were observed and identified during the tour of the hospital on the afternoon of 10/15/2018 accompanied by the administrative staff, and on the afternoon of 10/16/2018 accompanied by the environmental staff. The presence of ligature risks in the physical environment of a psychiatric patient, including any setting where psychiatric patients may be present, even for a short period of time, compromises their right to receive care in a safe setting. These deficient practices were identified under this Conditions of Participation and were determined to pose Immediate Jeopardy to patient health and safety, and placed all patients at risk for the likelihood of harm, serious injury, and possibly subsequent death. Refer to TAG A0144 I.) protect Patient #1 and #49 from further harm by investigating to see if the children had been injured and needed further examination, if the physician had all the information to make an appropriate plan of care and potential examination, that the patient received appropriate counseling concerning the sexual abuse, and if the patients' CPS worker or legal representative was informed of the full extent of the sexual abuse that had occurred in the facility in 2 of 2 (Patients #1 and #49) charts reviewed. J.) identify events and occurrences of sexual abuse by investigating, monitoring, tracking, and	A 115		

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A 115	Continued From page 13 analyzing all incident reports to protect all patients from sexual abuse and harm. Refer to TAG A0145	A 115		
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on review of records, observation, and interview, the facility failed to: A) protect patients from sexual predators, and to identify predators and victims of sexual abuse in 2 (45 and 33) of 2 charts reviewed. B) provide timely staff education, an approved policy and procedure, or any plan of monitoring of room assignments for patient safety. C) provide a quality assurance performance improvement (QAPI) plan for sustainability of staff education, data collection through chart audits, or tracking method to prevent a patient from being a victim of sexual abuse. D) ensure medications given in a psychiatric emergency were ordered, administered, and monitored to make sure the medications were appropriate and safe in 6 out of 6 (Patient #21, #22, #27, #28, #20, and #33) patients reviewed. E) ensure, when medications were ordered by	A 144		

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A 144	Continued From page 14 physicians, the medication orders were documented by the physicians with the required elements. F) ensure Medical Staff provided oversight for the safety and appropriateness of medication administrations in a behavioral emergency through the peer review process per hospital policy. Medications given in a behavioral emergency were not analyzed and evaluated through hospital processes or programs to ensure safety and appropriate usage. Medications administered were not always monitored as behavioral restraints to ensure patient safety and appropriate usage. Psychotropic medications (medication capable of affecting the mind, emotions, and behavior) were observed to be given for staff convenience in 1 (Patient #33) out of 2 patients (Patient #32 and #33) for emergency behavioral medication administrations. Medications given without proper oversight and review of the Medical Staff and hospital administration, and given for staff convenience, have the likelihood for these medications to be abused by staff causing psychological harm to patients, physical harm during forced administration of medications, or for patients to become over sedated, resulting in the likelihood of death. G) develop policies and procedures that prevent the exchange of patient care information via text messaging unless it is on a secured platform. Patient care decisions were made via unsecured	A 144		

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text messaging by limiting patient identifying information. Without the use of appropriate patient identifiers, there is a likelihood for errors in patient care decisions.

H) provide a safe setting for the psychiatric patients. Ligature risks were observed and identified during the tour of the hospital on the afternoon of 10/15/2018 accompanied by the administrative staff and on the afternoon of 10/16/2018 accompanied by the environmental staff. The presence of ligature risks in the physical environment of psychiatric patients, including any setting where psychiatric patients may be present, even for a short period of time, compromises their right to receive care in a safe setting.

These deficient practices identified above were determined to pose Immediate Jeopardy to patient health and safety and placed all patients at risk for the likelihood of harm, serious injury, and possibly subsequent death.

The facility failed to protect patients from sexual predators, and to identify predators and victims of sexual abuse in 2 (45 and 33) of 2 charts reviewed, provide timely staff education, an approved policy and procedure, or any plan of monitoring of room assignments for patient safety, and provide a quality assurance performance improvement (QAPI) plan for sustainability of staff education, data collection through chart audits, or tracking method to prevent a patient from being a victim of sexual abuse.

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Findings:

Review of facility documents revealed no evidence on how the patient was to be protected from sexual predators, how to identify predators and victims of sexual abuse, any staff education, an approved policy and procedure, or any tracking and monitoring of sexual predators who were admitted to the facility in order to prevent other patients from becoming a victim of sexual abuse while admitted to the facility for care.

An interview was conducted with Staff #1 and Staff #2 in the morning of 10-15-2018 at 3:45PM. Staff #2 stated, there had been no staff training for sexual contact between patients. Staff #2 reported, the facility had not developed training module to address the issue. The administrative staff had not involved the medical staff and had not taken the training to Governing Body (GB) for approval as of 10-15-2018. Staff #2 reported, the GB was to meet the night of 10-15-2018.

Staff #1 reported, the facility had worked so hard on the first part of the previously cited deficiencies in relating to the intake process of the hospital, that they had not completed all the training needed to protect patients from sexual predators. Staff #1 stated, they would provide the training information in the morning of 10-16-2018 for review.

An interview was conducted on 10-16-2018 with

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Staff #1 and Staff #2. Staff #2 reported they had developed training for the staff. The administrative staff was asked what their plans were for staff before working with patients. Staff #2 stated, "I will make sure everybody is trained before they start work." Staff #2 reported that he had training sessions starting "today" (10-16-2018) and would catch everybody before their shifts start.

Review of Patient #45's chart revealed, she was admitted to the facility on 10/11/2018. Patient #45, a 27-year-old female, was brought to the facility on an Order of Protective Custody warrant for psychosis.

Review of the Patient #45's chart revealed, the patient was seen by a psychiatrist via telemedicine on 10-11-2018 at 15:33 (3:33PM) in the intake area. The physician wrote the following:

"27y/o CM with h/o polysubstance use DO, and schizoaffective DO was found in an ally, passed out. Pt then climbed firetruck and wouldn't come down, she reported that people were after her and she was trying to get away from them." Physician reported the patient was, "actively psychotic, delusions, disorientation, disorganized, hyper sexuality, hallucination." The psychiatrist did not write an order for an SAO precaution.

Review of the nurse's notes dated 10-12-2018 revealed Patient #45 was "touching others." There was no further documentation on how the patient was touching others.

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On 10-13-2018 at 9:05AM, nurse's notes stated, "Inappropriate sexual behavior with staff tried to kiss employees." A physician order was found on 10-13-2018 at 11:45AM, "please add SAO to patient's precautions." (sexually acting out precautions)

Review of the Patient Observation Round Sheet on 10-13-2018 through 10-17-2018 revealed there was no documentation that the Mental Health Technician (MHT) was aware the patient was on SAO precautions. There is a check box on the sheet that stated, "Observation level and precautions." The only things checked on the observation sheet was "every 15 minutes" for observation level and "S/P danger to self (suicide precautions)" for precautions. Observation Round Sheet found for 10-14-2018 did show the patient was on a SAO.

Review of Patient #45's nurse's notes for 10-14-2018 at 8:00AM revealed, the nurse had checked a box under Sexual Behavior Assessment as a "sexual predator."

Review of Patient #45's nurse's notes for 10-15-2018 at 7:48AM revealed, under the section Sexual Behavior Assessment a "N/A" was written. There was no documentation that the physician was called to reassess the patient, to see if she was no longer appropriate to be on SAO precautions. There was no order to discontinue the precautions. There was no further documentation of the patient's behaviors under

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A 144	Continued From page 19 the SAO physician orders. On 10-18-2018 in the afternoon, the surveyor found Patient #45 had a roommate. Patient #46 had been admitted to the facility on 10-17-2018 and was placed in Patient #45's room. There was no documentation that Patient #45 was on a 1:1 during the nighttime hours, or under constant supervision by a nurse, or that a physician order was written to remove the patient from SAO precautions. Review of the policy and procedure "Sexually Acting Out Precautions" revised on 10/16/2018 revealed: "PROCEDURE: 3. The RN will assess each patient for potential for sexually inappropriate behavior during the admission nursing assessment. The high risk areas are marked with an asterisk on the assessment, if any of these sections are checked, then place on SAO precautions. Any patient who has demonstrated sexually inappropriate behavior during hospitalization will be placed on SAO and remain on SAO precautions for the remainder of the hospitalization. a. The RN or MD may place a patient on SAO precautions. The MD is the only staff who can remove a patient from SAO precautions. b. The Treatment Team at weekly conferences will review the SAO precautions and behaviors necessitating the precautions. c. All personnel caring for the patient shall be sufficiently informed of the patient's status.	A 144		

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4. SAO precautions will be addressed on the Treatment Plan, and will be noted on the Precautions Sheets and Report Sheets to denote the appropriate concerns.

a. Treatment Plan Entry made and dated documenting the patient's sexually acting out status, with a description (brief) of the behavior that prompted the patient being placed on SAO precautions as well as if the patient has been a victim or perpetrator. b. Appropriate documentation will also be entered in the multidisciplinary notes. c. SAO precautions will be documented on the Patient Data and Assessment form.

6. Patient is to be housed in a private room when available. If a private room is unavailable, the patient on SAO's will sleep in the room across from the Nurse's station for close observation. If a room across from the Nurse's station is not available, the patient will be placed on a COHS "Continuous Observation at Night" observational level.

7. General Safety Procedures to be enforced:
a. Report and record all sexual remark and gestures. b. Never leave patient unattended with other patients. c. Perpetrators will be redirected from situations that might stimulate negative behaviors. d. Victims will be observed closely and staff will maintain a safe environment avoiding potential threats."

An interview was conducted in the afternoon on 10-18-2018 with Staff #41 (RN). Staff #41 reported to surveyor that Patient #45 was in room 105 and had a roommate. Staff #41 reported the

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roommate had come the night before. Staff #41 was not aware Patient #45 was on a SAO. Staff #41 stated, "I guess they forgot to tell me in report." Staff #41 stated, "I don't know why she is on a SAO precaution. She has not been acting out. Only took her pants down a couple of times." Staff #41 confirmed, she had not called the doctor to reevaluate the patient because the Staff #41 was not aware the patient was on precautions. Staff #41 confirmed for the MHT to know about the precautions the nurse would have to instruct them at the beginning of the shift. Staff #41 reported that she had not been to any of the training on SAO but planned to go after she got off work today. Staff #41 had been allowed to work without being provided the necessary training.

Review of the treatment plan for Patient #45 revealed there was no problem addressed for the SAO.

An interview was conducted with staff #4 on the morning of 10/17/2018. Staff #4 was asked about performance improvement projects and what type of projects are going on at the present. Staff #4 was unable to provide any documentation of current or ongoing performance improvement projects concerning the ongoing deficiencies the facility received on 8/31/2018. Staff #4 reported that he did not have any current projects written or reported at this time. Staff #4 was unable to provide any monitoring data or chart reviews of SAO's or patient safety since 8-31-2018.

An interview was conducted in the afternoon on

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10-18-2018 with Staff #2 and #1. Staff #2 confirmed Staff #41 had not had the SAO training and was allowed to work. Staff #2 reported that he thought he had until the end of the CMS survey to complete the training of staff. Staff #2 was reminded by the surveyor that he had agreed to have all staff trained before they worked with the patient population. Staff #1 and #2 was unable to tell the survey team how many patients in the facility were identified as sexual perpetrators, what units those patients had been assigned, and if those patients had been placed on SAO precautions while in the facility. There was no tracking in place to monitor, assess, or identify who was on SAO precautions, who was a sexual predator, and if patients were safe in the facility.

In the afternoon on 10-19-2018 an interview was conducted with Staff #1, #2, #3, and #4. Staff #1 submitted an Abatement Plan for "Sexual Acting Out." This plan was submitted after the surveyors made the administrative staff aware of the failure to address this as part of the Immediate Jeopardy on 8-31-2018.

The facility failed to ensure medications given in a psychiatric emergency were ordered, administered, and monitored to make sure the medications were appropriate and safe in 6 out of 6 (Patient #21, #22, #27, #28, #20, and #33) patients reviewed. The faility failed to ensure Medical Staff provided oversight for the safety and appropriateness of medication administrations in a behavioral emergency through the peer review process per hospital

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policy. Medications given in a behavioral emergency were not analyzed and evaluated through hospital processes or programs to ensure safety and appropriate usage. Medications administered were not always monitored as behavioral restraints to ensure patient safety and appropriate usage. Psychotropic medications (medication capable of affecting the mind, emotions, and behavior) were observed to be given for staff convenience in 1 (Patient #33) out of 2 patients (Patient #32 and #33) for emergency behavioral medication administrations.

Findings:

Review of patient #50's chart revealed, she was a 13-year-old female admitted on 10/29/17. Patient #50 was admitted with a diagnosis of Bipolar disorder, current episode mixed, severe without psychotic features.

Review of the physician orders revealed the patient was ordered "seclusion, Zyprexa 5 mg IM, and Benadryl 25 mg IM now for sever agitation and aggression." Review of the Restraint /Seclusion record dated 10-30-18 at 2145 (9:45PM) revealed, patient was "hitting, yelling, scratching staff." Review of the chart revealed, no documentation that patient #50's mother or any legal guardian was notified of the seclusion or emergency medication administration.

Review of the nurse's notes dated 11/3/17 at 2130 (9:30PM) revealed, the nurse documented,

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"Pt has been given HS meds and instructed to go to bed multiple times by multiple staff. Pt refuses, sitting out in dayroom. Pt began hitting walls, windows and counters with hands. Pt started bouncing paper towels off walls and began to upset other peers. Pt continued to increase verbally yelling at staff and continues to refuse to go simply lay down in room. Will notify MD. 2138 (9:38PM) phoned on call MD ____ (staff #45) and orders received for IM injections. Consents for IM meds on chart from previous Monday. 2149 (9:49PM) House supervisor____ notified of injection given.2157 (9:57PM) Attempt to notify parents, left voice msg at (phone number) to update on meds given.2218 (10:18PM) pt asleep in bed w/o further concern or distress. Continue to maintain safety w/q 15 minute checks."

Review of patient #50's chart revealed a physician order written on 11/3/17 at 2138 (9:38PM). The physician order stated, "Give IM injection x1 Now of Benadryl 25 mg IM and Zyprexa 5 mg IM for severe agitation."

Review of patient #50's chart revealed, no Restraint /Seclusion record documented for the emergency behavioral medication administered on 11/3/18. There was no documentation found of the patient receiving any therapeutic interventions before giving a chemical restraint, face to face assessment, nursing assessments, vital signs, or continuing nursing interventions. There was no attempt documented to contact the legal guardian regarding the medication administration.

The facility failed to ensure medications given in a psychiatric emergency were ordered,

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administered, and monitored to make sure the medications were appropriate and safe in 6 out of 6 (Patient #21, #22, #27, #28, #20, and #33) patients reviewed. The facility failed to ensure that when medications were ordered by physicians, the medication orders were documented by the physicians with the required elements. The facility failed to ensure that Medical Staff provided oversight for the safety and appropriateness of medication administrations in a behavioral emergency through the peer review process per hospital policy. Medications given in a behavioral emergency were not analyzed and evaluated through hospital processes or programs to ensure safety and appropriate usage. Medications administered were not always monitored as behavioral restraints to ensure patient safety and appropriate usage. Psychotropic medications (medication capable of affecting the mind, emotions, and behavior) were observed to be given for staff convenience in 1 (Patient #33) out of 2 patients (Patient #32 and #33) for emergency behavioral medication administrations.

Findings:

A review was made of psychotropic medications (medication capable of affecting the mind, emotions, and behavior) that were given through Intramuscular (IM) route. Haldol injections, Geodon injections, Thorazine injections and Zyprexa injections were reviewed for a 6-month period of 4-15-2018 to 10-15-2018.

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A total of 985 doses were identified as requiring an override for "Emergency Use" or "Other". Medications that did not require an override or were identified as requiring an override for "Initial Dose" were not counted.

Review of medical records for Patient #21, #22, #27, #28, #20, and #33 did not contain why the medication was necessary, other less restrictive measures used that were not effective, and evaluation of patient.

Review of Policy #801.00, Peer Review and Performance Monitoring, Effective 12-2-2013 was as follows:

"PURPOSE

To provide a mechanism whereby the Medical Staff ensures that the Medical Staff approved Peer Review Criteria are effectively monitored for all members of the Medical Staff in an organized and fair manner, and that a process for performing an ongoing evaluation of each practitioner's professional practice and abilities to perform requested clinical privileges has been defined to include at a minimum, requests for initial appointment and at reappointment.

PEER REVIEW CRITERIA

Criteria for review will be developed and approved by the Medical Staff. Peer Review cases are identified by, but not limited to, the following Peer Review Criteria. Cases are identified by direct knowledge of the case,

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A 144	Continued From page 27 incident reports, patient complaints, and regulatory agency review or routine case review. Reviews may include: Cardiac or Respiratory Arrest Death in Facility Restraint/Seclusion Review Inadequate Medical Record Documentation Significant Adverse Drug Reaction Medical Management / Miscellaneous Significant Complaint Other as deemed reviewable Peer review cases will be reviewed and scored as a "1" through "6" by the initial reviewer/screener and results will be forwarded to the Medical Executive Committee for the review and final determination of the variation code, if necessary...." An interview was conducted with Staff #37 on the morning of 10-19-2018. Staff #37 stated, Peer Review was conducted 90 days after medical staff was hired and when reappointed at the 2-year reappointment. Staff #37 stated, she was not aware of a peer review committee or a mechanism/process for other issues to go before peer review. An interview was conducted with Staff #35, Medical Director. Staff #35 stated, there was not a peer review committee. Staff #35 stated, the Medical Executive Committee looks at cases but there was not a formal process. Staff #35 was not familiar with the process for an initial reviewer/screener to review cases, score them, and forward to the Medical Executive Committee	A 144		

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A 144	Continued From page 28 for review and final determination, per policy. Because of the failure to follow the policy, this prevented psychotropic medications administered during a behavioral emergency, and being monitored as a restraint, from being screened and reviewed by the Medical Staff and facility for the likelihood for overuse or misuse. Review of Quality/Process Improvement (QAPI) reporting provided by Staff #4 revealed, there was no mechanism for audit or analysis of psychotropic medications given during a psychiatric emergency to ensure that a true psychiatric emergency existed and that the medication was appropriate. No Process Improvement (PI) initiatives were identified to improve the overall facility performance in the use of psychotropic medications in a behavioral emergency. An interview was conducted with Staff #2 on 10-16-2018. Staff #2 stated that if the patient accepted the shot willingly and signed a consent, staff did not monitor the shot as behavioral restraint used in an emergency situation. However, if the patient refused to consent, they were given the shot anyway because it was a behavioral emergency. No mechanism was in place to ensure that those patients who didn't sign consents and accepted medication injections were not held down by multiple staff and forced to receive the medication. No mechanism was in place to evaluate if the patient was calm enough to sign a consent and agree to receive the medication, was the medication actually needed	A 144		

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for a behavioral emergency where a patient was a danger to themselves or others.

Review of Patient #21's chart

Patient #21 was an 11-year-old boy admitted to the facility on 10-5-2018 with an admitting diagnosis of Major Depressive Disorder, recurrent severe without psychotic features. The patient was discharged on 10-11-2018.

On 10-5-2018 at 7:50 PM, an order was written for IM (intramuscular) Zyprexa 5 mg (milligram) x 1 dose and IM Benadryl 25 mg x 1 dose. The order did not include the reason for the medication being ordered. The medication was given. A restraint and seclusion package was initiated. Per nursing documentation on Nursing Assessment form and Narrative, the patient was first placed in seclusion. Because the patient continued to hit the wall and the door while in seclusion, "causing lots of noise and disturbance" he was administered IM Zyprexa and Benadryl. Nothing was documented about what type of danger the patient presented to himself or others.

On 10-6-2018 at 8:40 PM, an order was written for IM Zyprexa 5 mg x 1 dose and IM Benadryl 25 mg x 1 dose. The reason given was for aggression/agitation. The medication was given. This was a telephone order written by the nurse. No physician signature was found for the order. A restraint and seclusion package was initiated but not signed by the physician.

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On 10-8-2018 at 12:35 PM, an order was written for Haldol 5 mg, Benadryl 25 mg, and Ativan 1 mg to be given IM for increased agitation and increased aggression. The medication was given. A restraint and seclusion package was initiated.

On 10-8-2018 at 5:40 PM, an order was written for Haldol 5mg and Benadryl 25 mg to be given IM for severe agitation and increased aggression. The medication was given. No restraint and seclusion package was found.

Review of psychiatric progress notes from 10-6-2018 through 10-10-2018 did not contain mention of the need to give Patient #21 repeated doses of psychotropic medications in emergency behavioral situations.

Review of Patient #22's chart

Patient #22 was a 10-year-old girl admitted to the facility on 11-15-2017 with an admitting diagnosis of Disruptive Mood Dysregulation Disorder.

On 11-19-2017 at 8:37 PM, an order was written for Zyprexa 5 mg IM and Benadryl 25 mg IM to be given for Aggression. The medication was given. No restraint and seclusion package was found. Per nursing documentation on Nursing Assessment form and Narrative, the patient was "intrusive, disruptive, agitated, aggressive, rec'd IM Benadryl 25mg x 1 Zyprexa 5mg x 1. Pt went to quiet room still agitated. Pt in bed asleep at this

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time." The note was not timed, so unable to tell what time the note "Pt in bed asleep at this time" was made.

Review of psychiatric progress notes from 11-20-2017 showed a note that said, "Received emergency meds yesterday." The note did not contain information regarding specific medical or behavioral condition why the order was necessary, other less intrusive forms of treatment attempted by staff, if any, that were evaluated and rejected, and why they were rejected.

Review of Patient #27's chart:

Patient #27 was a 9-year-old boy admitted to the facility on 9-21-2018 with an admitting diagnosis of Disruptive Mood Dysregulation Disorder.

On 9-27-2018 at 6:20 PM, an order was written for Haldol 5 mg, Benadryl 25 mg, and Ativan 1 mg to be given IM for increased agitation. The medication was given. No restraint package was found. An incident report was completed that confirmed emergency medications were given because the patient was a danger to self or others.

On 9-28-2018, the psychiatric progress note documented the patient was instigating others, was not following directions, and needed frequent staff interventions to reduce aggression towards others. Psychiatrist notes did not address the need for emergency behavioral medication

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A 144	Continued From page 32 administrations. On 10-8-2018 at 12:35 PM, an order was written for Haldol 5 mg, Benadryl 25 mg, and Ativan 1 mg to be given IM for increased agitation and increased aggression. A restraint package was initiated for medication and a hold. The box for the patient being placed in seclusion and the start/stop times were blank. The Multidisciplinary Progress Note contained an entry on 10-8-2018 at 2:13 PM, "Patient was in seclusion during class today." No other information about the seclusion was charted on the Multidisciplinary Progress Note. On 10-8-2018, the psychiatric progress note documented the patient was "Defiant, agitated easily, aggressive towards peers and staff; received emergency meds today." Psychiatrist notes did not address the need for emergency behavioral medication administrations. Psychiatrist notes did not address other generally accepted, less intrusive forms measures used by staff, if any, that the physician has evaluated but rejected; and the reasons those measures were rejected. Review of Patient #28's chart: Patient #28 was a 53-year-old female admitted to the facility on 6-17-2018 with an admitting diagnosis of Schizophrenia. On 6-21-2018 at 6:10 PM, the nurse wrote a	A 144		

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telephone order for Geodon 20 mg and Ativan 2 mg to be given IM for agitation/aggression. The medication was given per the Medication Administration Record (MAR). No restraint and seclusion package was found. Psychiatrist notes did not address the need for emergency behavioral medication administrations.

On 6-29-2018 at 7:27 AM, the nurse wrote a telephone order for Zyprexa 10 mg and Benadryl 50 mg IM for agitation. This order was not signed by the physician. The medication was given per the MAR. No restraint and seclusion package was found. Psychiatrist notes addressed the need for emergency behavioral medication administrations; but, did not address other less intrusive measures used by staff, if any, that the physician has evaluated but rejected; and the reasons those treatments were rejected.

On 6-29-2018 at 3:15 PM, the nurse wrote a telephone order for Geodon, 20 mg IM and Ativan 2 mg IM for agitation. This order was not signed by the physician. The medication was given per the MAR. No restraint and seclusion package was found. Psychiatrist notes addressed the need for emergency behavioral medication administrations but did not address other less intrusive measures used by staff.

On 6-30-2018 at 3:25 PM, the nurse wrote a telephone order for Zyprexa 10 mg and Benadryl 50 mg IM for agitation. The medication was given per the MAR. No restraint and seclusion package was found. Psychiatrist notes addressed the need for emergency behavioral medication

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administrations but, did not address other less intrusive measures used by staff, if any, that the physician has evaluated but rejected; and the reasons those measureswere rejected.

On 7-4-2018 at 11:15 AM, the nurse wrote an order for Geodon 20 MG and Ativan 2 mg IM for increased agitation and psychosis. This order was not signed by the physician. The medication was given per the MAR. No restraint and seclusion package was found. Psychiatrist notes did not address the need for emergency behavioral medication administrations.

Review of Patient #20's chart:

Patient #20 was a 15-year-old admitted on 9/16/2018 with a diagnosis of auditory hallucinations, flights of ideas, impaired thinking, hyperactive, suicidal, patient running across streets in traffic.

Patient #20 was a current patient as of 10/19/2018. Twelve emergency IM injections were ordered. Nine injections were given from 9/16/2018 through 10/19/2018 end of survey. Two injections (9/28/18 and 10/05/18) did not have restraint/seclusion orders and 3 injections were refused per patient.

On 9/16/2018 5:30 PM, the nurse charted, "encourage to take anxiety medication, pt refuse injection of Haldol 5mg, Ativan 2mg, Benadryl 50mg. Seclusion criteria for release calm and

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A 144	Continued From page 35 aggressive for 15 minutes, pt agree, release 1830." 9/17/2018 0840 encourage to take anxiety medication, pt refused injection of Haldol 5mg, Benadryl 50mg for agitation, calm in dayroom, refuse vital signs. 9/21/2018 1220 Zyprexa 5mg, Benadryl 25mg order not given. Seclusion no PRN 9/24/2018 1335 Haldol 5mg, Ativan 1mg, Benadryl 25mg IM severe aggression, seclusion 1158-1240 On 9/28/2018 at 9:20 AM, a physician order was found for Zyprexa 5mg and Benadryl 25mg IM for severe aggression. 10/01/2018 0910 Zyprexa 5mg Benadryl 25mg IM severe aggression, seclusion end 0935 10/02/2018 1155 Haldol 5mg, Ativan 1mg, Benadryl 25mg IM severe aggression, seclusion 1158-1240 10/04/2018 0955 Haldol 5mg, Ativan 1mg, Benadryl 25mg IM severe aggression, seclusion 0850-0955 Review of nursing progress note from 10/05/2018	A 144		

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stated, 1632 Pt in dayroom with other patients watching TV. No complaints noted at this time. Late entry 1530, patient stumping feet yelling screaming. Provider order injection to be given to patient. 1530 shot given.

10/06/2018 1400 Zyprexa 10mg Benadryl 50mg IM severe agitation, seclusion 1415-1500

10/08/2018 0845 Haldol 5mg, Ativan 1mg, Benadryl 25mg IM severe aggression, seclusion 0845-1000

10/11/2018 0930 Haldol 5mg, Ativan 1mg, Benadryl 25mg IM severe aggression, seclusion 0930-1130

Review of Patient #33's chart:

Review of the medical record for Patient #33 on the morning of 10/18/2018 revealed, Patient #33 was a 12-year-old boy admitted to the facility on 09/21/2018 with an admitting diagnosis of Disruptive Mood Dysregulation Disorder (Adolescent). The patient was a current inpatient on Unit 5 at the time of the survey.

Review of a Daily Nursing Assessment note, dated 9/27/2018, read in part, "1720 (5:20 PM) Patient alert, oriented X3, very hyperactive, easily irritated. Acting out, running up and down the unit. Refused to follow unit instruction. Send to his room for time out continuous re-directing but

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still pt didn't want to follow instruction." "1820 (6:20 PM) - _____ (Staff #23, physician) ordered emergency medication Haldol 5mg/IM (in muscle), Ativan 1 mg/IM and Benadryl 25mg/IM for agitation - and administered to the patient." The nurse narrative also stated "1900 (7:00 PM) - Patient in his bed sleep and no distress observed. Will continue to monitor q15 mins for safety." The review revealed there was no restraint and seclusion package initiated. There were no documented vital signs for 09/27/2018 after the administration of the emergency medication injection.

Review of the "Medication Administration Record" dated 09/27/2018 read in part "Haldol 5mg/IM, Benadryl 25mg/IM, Ativan 1 mg/IM X1 for agitation" was given at "1825" (6:25 PM).

Review ofthe "Patient Observation Rounds" dated 9/27/2018 documented that from 1715 - 1815, (5:15 PM - 6:15 PM) Patient #33 was in the dayroom interacting with peers; 1830 (6:30 PM) he was in dayroom watching TV; 1845 (6:45 PM) he was in the dayroom lying down; 1900-1945 (7:00 PM - 7:45 PM) he was in the dayroom and appears sleeping; 2000-2345 (8:00 PM - 11:45 PM) Patient #33 was in his room and appears sleeping.

An interview was conducted with the Director of Risk Management, Quality Assurance Performance Improvement (QAPI), Staff #4, on the afternoon of 10/18/2018 at approximately 4:30 PM after the surveyors watched the video of activity on Unit 7 on 09/27/2018. When Staff #4

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was asked if he saw any behaviors that posed a danger to self or others shown by Patient #33 that warranted the documented Haldol 5mg/IM, Benadryl 25mg/IM, Ativan 1 mg/IM medication for agitation, Staff #4 stated "I didn't see any agitation that warranted the shot." When Staff #4 was asked if he saw any staff interventions to talk with Patient #33 prior to the administration of the injection, Staff #4 stated "No."

An interview was conducted with a Charge RN, Staff #34, on the morning of 10/19/2018 at approximately 8:30 AM in the hospital conference room. After Staff #34 reviewed her nursing noted dated 09/27/2018 in the medical record of Patient #33, she was asked if she could explain why the 12-year-old patient was medicated with an injection of Haldol 5mg, Benadryl 25mg, and Ativan 1 mg. Staff #34 stated the patient was running around the unit and would not settle down. Staff #34 stated "I tried to talk to the baby. We've told him to sit down. Before we administer this medication we will try to talk with them. We call our male figures to talk with them. Sometimes we take them to seclusion and we just give them a time out." When Staff #34 was asked if staff monitored patients while they are in a time out in seclusion, Staff #34 stated "We have somebody there to watch them. We will call a float MHT (Mental Health Technician) to come help." After Staff #34 reviewed the "Patient Observation Rounds" dated 9/27/2018 that was completed by the unit MHTs, she was asked if she saw any documentation that Patient #33 had been agitated, running, or yelling. Staff #34 stated "I don't see it." When Staff #34 was informed that the surveyors had watched a video of Patient #33's behavior on the unit prior to the

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administration of the injection and that the surveyors observed him sitting in a chair watching cartoons, Staff #34 stated "The baby was running around and wouldn't listen to us is all I know."

Staff #34 was asked what was the nursing policy for monitoring patient after emergency IM medications are administered. Staff #34 stated "We check the vital signs 30 minutes after giving the meds."

When Staff #34 was asked how often are the boys on her unit permitted to go to the gym. Staff #34 stated "We have to take turns in the gym. After dinner we can sometime take them to the gym; maybe every other day. When they go to the gym it's my techs that have to take them to the gym. They have to go with 2 staff." Staff #34 stated that after 3:00 PM is when trouble starts because the boys have activities in the morning to keep them busy."

The facility failed to develop policies and procedures that prevent the exchange of patient care information via text messaging unless it is on a secured platform. Patient care decisions were made via unsecured text messaging by limiting patient identifying information. Without the use of appropriate patient identifiers, there is a likelihood for errors in patient care decisions.

Findings:

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A 144	Continued From page 40 Review of the Complaints and Grievance Log for August 2018 revealed that Patient #44 had made a grievance on 8-17-2018. The Summary of Resolution read, "Patient signed AMA request, and talked with his mother and stated he needs to be out of the hospital before Monday, or he would lose everything, his job, apartment, and truck. Patient Retracted the AMA and agreed to go with treatment team discharge plan. Update: Texted (Physician Staff #35) letting him know patient his mother stated they wanted PHP when he is discharged. (Physician Staff #35) texted back and said ok." Interview was conducted with Staff #19. Staff #19 stated, he had not processed this grievance. When asked if physicians are texted, Staff #19 stated they were, but patient names were not exchanged. Staff #19 stated, staff would use identifiers, such as "A.A." for patient initials. When asked if the company used a secure text program or platform, Staff #19 stated no. Without the use of appropriate patient identifiers, there is a likelihood for errors in patient care decisions. Staff #3 was asked about the use of secure platforms for text communication. Staff #3 confirmed the facility did not have one. Staff #3 was asked to provide a policy on use of cell phones for communication with physicians. Staff #3 provided a Human Resources policy, HR 300.3-07, Title: Cellular Phone/PDA Policy, Review Date: 2/15/2017. Review showed the policy did not include policies or processes for communicating patient information with the physician via text messaging. No other policy was provided.	A 144		

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The facility failed to ensure a safe setting for the psychiatric patients. Ligature risks were observed and identified during the tour of the hospital on the afternoon of 10/15/2018 accompanied by the administrative staff and on the afternoon of 10/16/2018 accompanied by the environmental staff. The presence of ligature risks in the physical environment of psychiatric patients, including any setting where psychiatric patients may be present, even for a short period of time, compromises their right to receive care in a safe setting.

Findings:

During a tour of the hospital on 10/15/2018 accompanied by administrative staff, and on 10/16/2018 accompanied by the environmental staff, ligature risks were identified throughout the hospital including the patient's gym, inside patient units, laundry rooms, and dining area.

In an interview with Staff #20 during the general tour of the hospital on the afternoon of 10/15/2018, the exit and entrance doors to units 1 and 2 were observed to have large hinges. Staff #20 said, patients are never left alone in these areas. The surveyor mentioned to Staff # 20, that doors should be equipped with anti-ligature hardwares. Staff #20 agreed with the findings.

In an interview with Staff #14 and #7 on the afternoon of 10/16/2018, during the

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environmental tour of the hospital including the patients' gym, units (1, 2, 3, and 4), dining area, laundry rooms, and entry doors to the seclusion rooms were observed to have large hinges that swung out from the doors creating ligature risks. Staff # 7 and # 14 agreed with the findings. The physical environment for patients at risk for suicide or other forms of self-harm or violent behaviors toward others, should be free of ligature risks.

The facility failed to ensure medications given in a psychiatric emergency were ordered, administered, and monitored to make sure the medications were appropriate and safe in 6 out of 6 (Patient #21, #22, #27, #28, #20, and #33) patients reviewed. The facility failed to ensure that when medications were ordered by physicians, the medication orders were documented by the physicians with the required elements.

Findings:

Review of the medical record for Patient #33 on the morning of 10/18/18 revealed, Patient #33 was a 12-year-old boy admitted to the facility on 09/21/2018 with an admitting diagnosis of Disruptive Mood Dysregulation Disorder (Adolescent). The patient was a current inpatient on Unit 5 at the time of the survey.

Review of a "Daily nursing Assessment" dated 9/27/18 that read in part, "1720 Patient alert, oriented X3, very hyperactive, easily irritated.

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A 144	Continued From page 43 Acting out, running up and down the unit. Refused to follow unit instruction. Send to his room for time out continuous re-directing but still pt didn't want to follow instruction." 1820 - Dr. _____ ordered Emergency medication Haldol 5mg/IM (in muscle), Ativan 1 mg/IM and Benadryl 25mg/IM for agitation - and administered to the patient." The nurse narrative also stated, "1900- Patient in his bed sleep and no distress observed. Will continue to monitor q15 mins for safety." The review revealed there was no restraint and seclusion package initiated. There were no documented vital signs for 09/27/18 after the administration of the emergency medication injection. Review of the "Medication Administration Record" dated 09/27/2018 read in part "Haldol 5mg/IM, Benadryl 25mg/IM, Ativan 1 mg/IM] X1 for agitation" was given at "1825." Review of the "Patient Observation Rounds" dated 9/27/18 documented that from 1715 - 1815, Patient #33 was in the dayroom interacting with peers; 1830 he was in dayroom watching TV; 1845 he was in the dayroom lying down; 1900-1945 he was in the dayroom and appears sleeping; 2000-2345 Patient #33 was in his room and appears sleeping. An interview was conducted with the Director of Risk Management, Quality Assurance Performance Improvement (QAPI), Staff #4 on the afternoon of 10/18/18 at approximately 4:30 pm after the surveyors watched the video of activity on Unit 7 on 09/27/18. When Staff #4	A 144		

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was asked if he saw any behaviors that posed a danger to self or others shown by Patient #33 that warranted the documented Haldol 5mg/IM, Benadryl 25mg/IM, Ativan 1 mg/IM medication for agitation. Staff #4 stated "I didn't see any agitation that warranted the shot." When Staff #4 was asked if he saw any staff interventions to talk with Patient #33 prior to the administration of the injection Staff #4 stated "No."

An interview was conducted with a Charge RN Staff #34 on the morning of 10/19/18 at approximately 8:30 am in the hospital conference room. After Staff #34 reviewed her nursing noted dated 09/27/18 in the medical record of Patient #33 she was asked if she could explain why the12 year old patient was medicated with an injection of Haldol 5mg, Benadryl 25mg, and Ativan 1 mg. Staff #34 stated the patient was running around the unit and would not settle down. Staff #34 stated "I tried to talk to the baby. We've told him to sit down. Before we administer this medication we will try to talk with them. We call our male figures to talk with them. Sometimes we take them to seclusion and we just give them a time out." When Staff #34 was asked if staff monitored patients while they are in a time out in seclusion, Staff #34 stated "We have somebody there to watch them. We will call a float MHT to come help." After Staff #34 reviewed the "Patient Observation Rounds" dated 9/27/18 that was completed by the unit MHTs she was asked if she saw any documentation that Patient #33 had been agitated, running, or yelling. Staff #34 stated "I don't see it." When Staff #34 was informed that the surveyors had watched a video of Patient #33's behavior on the unit prior to the administration of the injection and that the

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A 144	Continued From page 45 surveyors observed him sitting in a chair watching cartoons, Staff #34 stated "The baby was running around and wouldn't listen to us is all I know." Staff #34 was asked what was the nursing policy for monitoring patient after emergency IM medications are administered. Staff #34 stated "We check the vital signs 30 minutes after giving the meds." When Staff #34 was asked how often are the boys on her unit permitted to go to the gym. Staff #34 stated "We have to take turns in the gym. After dinner we can sometime take them to the gym; maybe every other day. When they go to the gym it's my techs that have to take them to the gym. They have to go with 2 staff." Staff #34 stated that after 3:00 pm is when trouble starts because the boys have activities in the morning to keep them busy."	A 144		
A 145	PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT CFR(s): 482.13(c)(3) The patient has the right to be free from all forms of abuse or harassment. This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to: A) protect Patient #1 and #49 from further harm by investigating to see if the children had been injured and needed further examination, if the physician had all the information to make an appropriate plan of care and potential	A 145		

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examination, that the patient received appropriate counseling concerning the sexual abuse, and if the patients' CPS worker or legal representative was informed of the full extent of the sexual abuse that had occurred in the facility in 2 of 2 (Patient #1 and Patient #49) charts reviewed.

B) identify events and occurrences of sexual abuse by investigating, monitoring, tracking, and analyzing all incident reports to protect all patients from sexual abuse and harm.

Review of Patient #1's chart revealed the patient was admitted on 7/16/2018. He was an 11-year-old Hispanic male that was placed on the children's unit. Patient #1 was brought in by his case worker with Child Protective Services (CPS).

Review of Patient #1's psychosocial assessment dated 7/18/2018 at 5:00 PM revealed, the patient was having fights, becoming more aggressive, and running away from the shelter he lived at. "Patient reported to therapist that he felt that he wanted to kill himself by choking himself but currently reports no SI." Review of the section on abuse or self-harm the patient denied any sexual abuse as a victim or predator.

Review of the physician's psychiatric evaluation completed on 7-17-2018 revealed, the patient was feeling "helpless and hopeless". The physician documented, "In foster care - sibling was abused in bio-home. Children removed 7 weeks ago." There was no documentation on what type of abuse occurred in the home. The psychiatrist did not document any questioning of sexual abuse with the child.

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A 145	Continued From page 47 Review of the physician orders for admission on 7/17/2018 at 0020 (12:20AM) revealed the patient was placed on suicidal precautions-moderate and every 15 minute checks. Review of the nurse's notes dated 7/25/2018 at 1330 (1:30PM) revealed, the nurse documented, "Pt. was found engaging in sexually inappropriate behavior with roommate. No acute distress noted. 1345 (1:45PM) Dr. ____ (Staff #23) notified. 1424 (2:24PM) CNO notified/ House Sup (1435) notified. 1357 (1:57PM) Attempted to contact CPS_____ (name of CPS worker) voicemail left. 1707 (5:07PM) _____ (name of CPS worker) notified; thankful for call." There was no further information documented from the nurse concerning the incident, what happened, the physical or emotional condition of Patient #1 or #49, or how the nurse protected the patients from further harm. Review of the physician orders revealed a telephone order was written on 7/25/2018 at 1345 (1:45PM). The order stated, "ADD SAO PRECAUTION 1:1 observation due to SAO with roommate." A physician order was found on 7/25/2018 at 1530 (2:30PM) BLOCK ROOM (SAO behavior) pt. to have 1:1 observation if he gets a roommate." Review of the nurse's notes dated 7/25/17 at 1755 (5:55PM) stated, "Patient was placed on 1:1 at the beginning of the shift for SAO behavior until his room was blocked. Roommate _____ (illegible word) removed to another room for	A 145		

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safety. Will continue to monitor closely." There was no further documentation found concerning the patient sexual abuse in the nurse's notes.

Review of the Patient Observation Rounds sheet revealed, no documentation that the patient was on a 1:1. The Mental Health Technician (MHT) documented the patient was in his room from 1:30PM-2:00PM and back in his room from 3:00PM -4:30.

Review of the psychiatric progress note dated 7/26/2018, 8:20PM, revealed, no documentation concerning the sexual abuse. The physician documented "awaiting placement." There was no documentation of a medical exam done concerning the sexual abuse. Review of the physician discharge summary dated 8/7/2018 revealed, no documentation of the sexual abuse, SAO precautions or any therapy to help the child cope with the incident.

Review of the progress notes on 7/25/2018 at 5:07PM revealed, staff #25 (social worker) documented, "called the patients caseworker _____ (name of CPS worker) to make her aware of the incident that happened with another patient. I did make her aware that him and another male patient were having poor boundaries with one another and touching each other inappropriately. I made the case worker aware that the patient was placed on a 1:1; and SAO precautions. The case worker said thank you for making her aware and she had no further questions nor concerns at this time. (sic)"

An interview was conducted with Staff #25 in the afternoon on 10/16/2018. Staff #25 reported that she did remember the incident and Patient #1.

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Staff #25 confirmed that she had not interviewed the child and was repeating what she was told by the nurse, Staff #25 stated, "I didn't know there was penetration. I was told it was just inappropriate touching."

Review of the incident reports revealed, a report filed on 7/25/2018 at 1330 (1:30PM) for Patient #1. Staff #38, RN, filed the report. The report stated the patient was on unit 6 and it happened in the patient's room. The incident type was checked, "boundary violation with peer." In the description it stated, "see attached sheet." There was no attached sheets or information found. A witness was documented to be Staff #39, MHT. The back side of the report had a section for "additional findings and outcomes, was the patient sent out for additional evaluation? and follow up action taken." There was no information in these sections, left blank. The director of nursing signed and dated the form 7/26/2018. The risk manager also signed and dated the form on 7/26/2018 with no further evaluation. The other child involved in this incident, Patient #49, had the same incident report with no follow up.

An interview was conducted with Staff #39 on 10/16/2018 in the afternoon. Staff #39 reported that she witnessed the sexual encounter between the two 11-year-old boys on 7/25/2018. Staff #39 reported, during her 15 minute rounds she walked into the boys' room and found Patient #49 with his penis in Patient #1's anus. Staff #39 stated, "I told them to stop that. They both pulled up their pants and I separated them." Staff #39 reported that she took the boys to the nurse's station and reported to the nurse that Patient #49 was on top of Patient #1 and they were having sex. The surveyor asked Staff #39 if there was penetration

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and if she conveyed that to the nurse? Staff #39 stated, "Yes, there was penetration and I told the nurse exactly what I saw." Staff #39 reported, the nurse separated the boys and talked to them. Patient #1 went back to his room and didn't want to come back out. Staff #39 stated, "He was ashamed and embarrassed and didn't want anybody to ask him questions." Staff #39 was asked if she was ever interviewed or asked to write a statement about the incident and she stated, "No."

An interview with Staff #2 and #4 was conducted on 10/16/2018 in the afternoon. Staff # 2 and #4 were asked about the incident report written on Patient #1 and #49 on 7/25/2018. Staff #2 reported that he was not sure why the incident reports were not completed. Staff #4 reported that he was sure something was written on the issue but he was unable to provide any documentation. Staff #4 was unable to explain to the surveyor how the incidents were managed, investigated, or analyzed for reporting to medical staff and governing board. Staff #2 and #4 failed to protect patient #1 from further harm by investigating to see:

if the child had been injured and needed further medical examination or care;

if the physician had all the information to make an appropriate plan of care and potential examination for psychological harm;

that the patients received appropriate counseling concerning the sexual abuse;

if the patients' CPS worker or legal representative was informed of the full extent of the sexual

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A 145	Continued From page 51 abuse that had occurred in the facility; or monitor, track, and analyze other incidents to protect all patients from sexual abuse and harm.	A 145		
A 263	QAPI CFR(s): 482.21 The hospital must develop, implement and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors. The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS. This CONDITION is not met as evidenced by: Based on review and interview, the facility failed to: A) assess data to set priorities for performance improvement (to include annual Nurse Staffing Plan). B) consider the incidence, prevalence, and severity of problems or to focus on problem prone areas that affected health outcomes, patient safety, and quality of care.	A 263		

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A 263	Continued From page 52 C) to measure any successful performance improvements or track performance to ensure that improvements are sustained. D.) to ensure an annual evaluation from the Nursing Advisory Committee was submitted to Quality Assurance Performance Improvement (QAPI) to determine adequacy of the nursing staffing plan. Refer to TAG A0283 E. ensure ongoing data analysis, tracking, and measurable performance improvements that identified and reduced medical errors, adverse events, and gave a clear expectation for patient safety. F.) ensure that the hospital had an active functioning safety program reporting data and performance improvement. Refer to TAG A0286	A 263		
A 283	QUALITY IMPROVEMENT ACTIVITIES CFR(s): 482.21(b)(2)(ii), (c)(1), (c)(3) (b) Program Data (2) [The hospital must use the data collected to - .....] (ii) Identify opportunities for improvement and changes that will lead to improvement. (c) Program Activities	A 283		

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A 283	Continued From page 53 (1) The hospital must set priorities for its performance improvement activities that-- (i) Focus on high-risk, high-volume, or problem-prone areas; (ii) Consider the incidence, prevalence, and severity of problems in those areas; and (iii) Affect health outcomes, patient safety, and quality of care. (3) The hospital must take actions aimed at performance improvement and, after implementing those actions, the hospital must measure its success, and track performance to ensure that improvements are sustained. This STANDARD is not met as evidenced by: Based on review and interview, the facility failed to; A) assess data to set priorities for performance improvement (to include annual Nurse Staffing Plan) B) consider the incidence, prevalence, and severity of problems or to focus on problem prone areas that affected health outcomes, patient safety, and quality of care. C) to measure any successful performance improvements or track performance to ensure that improvements are sustained. D.) to ensure an annual evaluation from the Nursing Advisory Committee was submitted to Quality Assessment and Performance Improvement (QAPI) to determine adequacy of the nursing staffing plan.	A 283		

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Review of the QAPI meeting minutes for 2018 revealed, there was only raw data reported to the Medical Staff and Governing Body. The data reported had no evidence to back up any monitoring, assessing, and evaluating patient safety practices and the quality of patient care, for identifying and resolving problems and for identifying opportunities to improve patient care, and services or performance throughout the facility.

Review of the facility's policy and procedure, "Organization Performance Improvement Plan" revealed, "Purpose: E. The hospital shall participate in a quality improvement organization(QIO) cooperative project or ensure its own performance projects are compared to a QIO in scope and quality. II. Goals of Performance Improvement:

A. The primary goals of the organizational Performance Improvement Plan are to continually and systematically plan, design, measure, assess and improve performance of critical focus areas, improve healthcare outcomes and reduce and prevent medical/health care errors. To achieve these goals, the plan strives to:

4.g. Utilizes the results of performance improvement. Patient safety, and risk reduction activities.

6. Assure that the improvement process is organization wide, monitoring, assessing and evaluating the quality and appropriateness of patient care, patient safety practices and clinical

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A 283	Continued From page 55 performance to resolve identified problems and improve performance. Appropriate reporting of information to the Governing Board to provide the leaders with the information they need in fulfilling their responsibility for the quality of patient care and safety is a required mandate of this plan. Organization:1. The Governing Body is responsible for the quality of patient care provided. a.The Governing Body requires the medical staff to implement and report on the activities and the mechanisms for monitoring, assessing, and evaluating patient safety practices and the quality of patient care, for identifying and resolving problems and for identifying opportunities to improve patient care and services or performance throughout the facility. This process addresses those departments/disciplines that have direct or indirect affect on patient care, including management, administrative functions and contracted services." An interview was conducted with Staff #4 on 10/17/2018. Staff #4 was asked about performance improvement projects and what type of projects are going on at the present. Staff #4 was unable to provide any documentation of current or ongoing performance improvement projects concerning the ongoing deficiencies the facility received on 8/31/18. Staff #4 reported that he did not have any current projects written or reported at this time. Staff #4 was asked what training or education he has received for QAPI. Staff #4 reported, he had	A 283		

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A 283	Continued From page 56 no certification and has had on-the-job training for Quality. Staff #4 was unsure how he was to report performance improvement and stated, "We talk about the issues and the department heads are supposed to go back and correct the issues and report back to me." Staff #4 was asked for that data or documentation of department heads correcting problems discussed and reporting back to him. Staff #4 reported he did not have written documentation. Staff #4 was unable to provide any quality data or performance improvement activities, to measure any successful performance improvements, or track performance to ensure that improvements are sustained. Review of the Nurse Advisory Committee meeting minutes did not reveal an annual evaluation of documented data that had been submitted to the QAPI Program to determine if the data related to the adequacy of the staffing plan. An interview was conducted with the Chief Nursing Officer (CNO), Staff #2, on the morning of 10/19/2018 at approximately 8:30 AM in the hospital conference room. When Staff #2 was asked if an annual evaluation of documented data of the nursing staffing plan had been submitted to the QAPI program, Staff #2 stated, "In our most recent meeting we discussed and evaluated the effectiveness of the staffing plan but we did not submit any data to the QAPI program."	A 283		
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3)	A 286		

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A 286	Continued From page 57 (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to: A) ensure ongoing data analysis, tracking, and measurable performance improvements that identified and reduced medical errors, adverse events, and gave a clear expectation for patient safety. B) ensure that the hospital had an active functioning safety program reporting data and performance improvement.	A 286		

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A 286	Continued From page 58 Review of the Quality Assessment and Performance Improvement (QAPI) meeting minutes for 2018 revealed, there was only raw data reported to the Medical Staff and Governing Body. The data reported had no evidence to back up any monitoring, assessing, and evaluating patient safety practices and the quality of patient care, for identifying and resolving problems and for identifying opportunities to improve patient care, and services or performance throughout the facility. Review of policy "Patient Safety Plan", effective 01/10/2010, stated "The patient safety plan provides a systematic, coordinated and continuous approach to the maintenance and improvement of patient safety through the establishment of mechanisms that support effective responses to potential or actual occurrences; ongoing proactive reduction in medical/health care errors; and integration of patient safety priorities into the new design and redesign of all relevant organization processes, functions and services." In an interview conducted with Staff #4 on the morning of 10/17/2018 at the facility. The surveyor asked for minutes of the safety meeting. Staff #4 said there were no minutes. No minutes of safety meetings were available for the surveyor to review. During the interview, Staff #4 agreed with the findings.	A 286		
A 392	STAFFING AND DELIVERY OF CARE CFR(s): 482.23(b)	A 392		

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A 392	Continued From page 59	A 392		

The nursing service must have adequate numbers of licensed registered nurses, licensed practical (vocational) nurses, and other personnel to provide nursing care to all patients as needed. There must be supervisory and staff personnel for each department or nursing unit to ensure, when needed, the immediate availability of a registered nurse for bedside care of any patient.

This STANDARD is not met as evidenced by:
Based on observation, review of records, and interview, the facility failed to ensure an adequate amount of staffing for the immediate availability of a Registered Nurse (RN) for patient care.

Findings:

Observation of the patient units during the facility tour on the afternoon of 10/15/2018 revealed, the staff bathrooms were in the break rooms that were located off the unit in a hallway between units. The surveyor observed that the only way for a Mental Health Technician (MHT) to contact the RN in the case of an emergency was to leave the locked patient unit and enter the locked break room. This would leave the patient unit without any available staff on the unit when unit staffing is one RN and one MHT.

An interview was conducted with the Chief Nursing Officer (CNO), Staff #2, on the afternoon of 10/17/2018 at approximately 3:10 PM in the facility conference room. When Staff #2 was asked if the current hospital staffing grid was developed according to best practices standards, he stated, "I can't say truthfully that they were.

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They were established and determined as the one used before I got here. We sometimes give Units 1 and 2 an alternate nurse. The Nurse Advisory Committee approved the staffing and the float nurse and float tech were what the committee requested. In one of our town hall meetings, the staff stated that 1 Mental Health Technician (MHT) was not enough so we now try to give 2 MHTs when possible." Staff #2 was asked if he thought that 1 MHT to 15-16 patients on the 11-7 shift was a safe staff to patient ratio and if this ratio took into consideration patients acuity and number of patients on suicide precautions as well as other duties the MHT has to complete during that shift. Staff #2 stated "The patients on those units usually sleep all night. If they need extra staff we use the float MHT to help out." Staff #2 was asked if the facility always had a float MHT and RN available to help out on units. Staff #2 stated that if an assigned staff calls in and they can't get a PRN staff to fill the shift then the hospital assigns the float nurse and/or MHT to staff the unit.

An interview was conducted with a House Supervisor RN, Staff #33, on the afternoon of 10/18/2018 at approximately 11:45 AM in a facility meeting room. When Staff #33 was asked how are unit nurses relieved for lunch breaks, he stated "We have a float nurse to cover lunches." Staff #33 stated that he will sometime help sit on units."

An interview was conducted with a Charge RN, Staff #34, on the morning of 10/19/2018 at approximately 8:40 AM in the hospital conference room. When Staff #34 was asked who relieved

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A 392	Continued From page 61 her for lunch breaks she stated "We have a float nurse to relieve me. When we are short staffed, we don't have someone to relieve me. I can't leave when we are short. I don't clock out to eat my lunch." Staff #34 stated that when she goes to the bathroom the float RN does not cover the unit for her because she is only off the unit for a "short time." Review of the facility policy titled "Staffing Plan, Policy #200.64, Revised: 09-03-2016" read in part, "To establish the number and qualifications of staff required to provide direct patient care. Procedure: A core staffing level is determined for each unit consisting of registered nurses, mental health technicians, social workers, and therapists." The policy also stated "The established staffing grid is utilized for core staffing, with adjustments made for acuity/activity. Changes in staffing needs during the shift are evaluated by the Nurse in Charge and communicated to the CNO/House Supervisor. The CNO/House Supervisor then utilizes existing in house staff or the PRN pool to meet the identified staffing needs as appropriate."	A 392		
A 395	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient.	A 395		

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A 395	Continued From page 62 This STANDARD is not met as evidenced by: Based on observation, review of records, and interview, the facility failed to ensure a registered nurse supervised and evaluated nursing care for each patient as Patient #33's care was not supervised as per hospital policy. Findings: Review of the medical record on the morning of 10/18/18 revealed, Patient #33 was a 12-year-old boy admitted to the facility to Unit 7 on 09/21/2018 with an admitting diagnosis of Disruptive Mood Dysregulation Disorder (Adolescent). The patient was a current inpatient on Unit 5 and was on Sexually Acting Out (SAO) precautions at the time of the survey. Observation of Unit 5, boys' unit, on the morning of 10/18/18 at approximately 11:15am accompanied by the Director of Training/Infection Control, the surveyor observed that Patient #33 was not in a blocked room or a room across from the Nurse's station. Patient #33's room was towards the end of patient rooms on the right side on the wall across from the Nurse's station. Staff could not fully see into Patient #33's room from the Nurse's station. An interview was conducted with the Charge RN Staff #19 on the morning of 10/18/18 at approximately 11:20 am on Unit 5, Boys unit. Staff #19 was asked how were patients with sexual acting out behavior admitted to the unit.	A 395		

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A 395	Continued From page 63 Staff #19 stated, "They are placed in a blocked or separate room. We enforce no touching boundaries." Staff #19 was asked if Patient #33 was in a blocked room and she stated "No. We have to have a doctor's order for a blocked room. We put him in a room on this side of the unit to watch him closer." When Staff #19 was asked why Patient #33 was not in a blocked room she stated "He's not in a blocked room because it was discovered he was sexually acting out towards girls." Review of the medical record on the morning of 10/18/18 revealed, Patient #33 was a 12-year-old boy admitted to the facility to Unit 7 on 09/21/2018 with an admitting diagnosis of Disruptive Mood Dysregulation Disorder (Adolescent). The patient was a current inpatient on Unit 5 and was on Sexually Acting Out (SAO) precautions at the time of the survey. Review of the "Admission Order for Dallas Behavioral" read in part "Suicide Precautions - Low, Assault Precaution - Perpetrator, Elopement" The order was signed off on 9/21/2018 by the attending physician. Review of facility documents titled "Patient Registration" dated 9/20/18 documented the reason Pt. #33 came in for an assessment were symptoms "very defiant, fighting, cursing, sexually acts." Review of the facility document titled "Intake to Unit Nurse Staff Hand-Off" dated 9/21/2018	A 395		

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A 395	Continued From page 64 stated in part "sexually acting out." Review of the physician orders dated 9/28/18 stated in part "Please add SAO to pt's precautions per intake handoff/assessment." Review of a psychiatric progress note dated 10/6/18 stated in part "Pt. claims he wants AIDS test due to unprotected sex prior to admission." Review of facility documents titled "House Supervisor Report" on the morning of 10/19/18 revealed that on Unit #5, Patient #33's assigned room of 206 was not a blocked room on dates 10/15/18, 10/16/18, 10/17/18, 10/18/18. The report dated 10/19/18 documented room 206 was a blocked room due to Sexual Acting Out (SAO) precautions ordered for Patient #33. Review of facility documents titled "Daily Patient Check List" revealed that Patient #33 had a roommate on 10/9/18 and 10/10/18 while he was on Sexual Acting Out (SAO) precautions. The "Check List" revealed that on 10/11/18, Patient #33 was moved to room 206 (with bed A and B) with a roommate while on SAO precautions. On 10/13/18 - bed 206B was blocked. On 10/16/18, Patient #33 on SAO precautions had a roommate in 206B; 10/18/18 & 10/19/18 - 206B was blocked. An interview was conducted with the Director of Risk Management, Quality Assurance Performance Improvement (QAPI), Staff #4, on	A 395		

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A 395	Continued From page 65 the afternoon of 10/18/18 at approximately 4:30 pm. Staff #4 was asked why Pt #33 was not in a blocked room since he was on sexually acting out (SAO) precautions. Staff #4 stated, "We don't have a blocked room for everyone that is on SAO precautions. We can't hold patients in intake any longer than necessary. We try to move them from intake as quickly as we can. We don't have enough rooms for blocked rooms for every patient on SAO precautions." The surveyor asked Staff #4 that if the unit did not have enough rooms to block for every patient that is on SAO precautions, why wasn't Patient #33 on 1:1 monitoring as per hospital policy. Staff #4 stated, there was a staffing issue. Review of the facility policy titled "Sexual Acting Out Precautions, Policy #200.50" with a revised date of "10/16/2018" stated in part Procedure: 5. The patient may be placed on 1:1 observational status if clinically indicated. 6. Patient is to be housed in a private room when available. If a private room is unavailable, the patient on SAO's will sleep in the room across from the Nurse's station for close observation. If a room across from the Nurse's station is not available, the patient will be placed on a COHS "Continuous Observation at Night" observational level. 7. General Safety Procedures to be enforced: a. Report and record all sexual remarks and gestures. b. Never leave patient unattended with other patients."	A 395		

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A 701	Continued From page 66	A 701		
A 701	MAINTENANCE OF PHYSICAL PLANT CFR(s): 482.41(a) The condition of the physical plant and the overall hospital environment must be developed and maintained in such a manner that the safety and well-being of patients are assured. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to A.) maintain the hospital in a safe manner to ensure the safety and well-being of patients. Multiple areas were observed which have the likelihood to cause harm to the patients and staff. B.) perform preventive maintenance on 2 of 2 washers and dryers located on 1st and 2nd floor laundry rooms for patient use. Findings: During a tour of the facility on afternoon of 10/16/18 accompanied by staff # 7 and 14, ligature risks were observed throughout the facility; patient's gym, patient units, laundry room, and dining area. A white powdery substance appearing to be plaster/paint peelings was observed on the floor in the corners in the seclusion rooms on units 1, 2, 3, and 4. The walls were not flush with the floors, leaving an opening for insects to enter. The door to the housekeeping room was not	A 701		

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A 701	Continued From page 67	A 701		

locked. A cart was observed with a large black plastic bag hanging on the handles of the cart.

The clear covering over the television screen mounted on the wall in the day room in unit 2 contained about 3-inch gap on the left side creating a sharp edge where patients and staff could be injured.

The entry door to the loading area was black with gummy substance. The weather stripping attached to the bottom of the door was missing about 16" of stripping creating an entry for rodents/insects.

The left corner guard across from the nursing station room on Unit 5 was cracked/loose revealing sharp edges.

During the environmental tour on the afternoon 10/16/2018 with staff #7 and #14, both staff agreed with the findings.

During a tour of the facility on 10/17/18 with staff #7 and #14 at 11:30 AM, staff #7 and #14 were unable to provide a preventive maintenance log for 2 of 2 washers and dryers for patient use. Staff #14 was interviewed during the tour and stated, "We do not perform preventative maintenance on the washers and dryers so we don't have a log."

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A 701	Continued From page 68 Review of Policy #IC 400.26, Titled: Washers and dryers in patient care areas, effective 02-28-2017 revealed: "1. Purpose: To assure that washers and dryers in patient care areas are clean and maintained on a regular basis ..."	A 701		
A 713	DISPOSAL OF TRASH CFR(s): 482.41(b)(4) (4) The hospital must have procedures for the proper routine storage and prompt disposal of trash. This STANDARD is not met as evidenced by: Based on observation and interviews, the facility failed to provide prompt removal of trash which caused unsanitary conditions. Findings: During the environmental tour on the afternoon of 10/16/2018 with staff #7 and 14, six green color mattresses, and multiple broken chairs were piled against and around the dumpsters. During the environmental tour on the morning of 10/18/2018 with staff #7 and 14, the same trash was observed around the dumpster. In an interview with the staff during the tour on the morning of 10/18/18 the surveyor asked staff # 7 how often is trash picked up. Staff #7 said, trash is picked up every day. But you have to call for bulk pickups. During the tour both staff agreed with the findings.	A 713		
A 715	REGULAR FIRE AND SAFETY INSPECTIONS CFR(s): 482.41(b)(6)	A 715		

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A 715	Continued From page 69 (6) The hospital must maintain written evidence of regular inspection and approval by State or local fire control agencies. This STANDARD is not met as evidenced by: Based on review of documentation and interviews, the facility failed to have annual fire building inspections to ensure the hospital is free from fire hazards. Findings: Review of form "Fire Safety Survey Report for Hospitals" on the day of survey, 9/22/2015 was the last fire inspection. The form stated, "annual fire safety inspections are required for continued licensure." In an interview during the environmental tour on the afternoon 10/16/2018 with staff #7 and 14, both staff agreed with the findings.	A 715		
A 748	INFECTION CONTROL OFFICER(S) CFR(s): 482.42(a) A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. This STANDARD is not met as evidenced by: Based on documentation review and interviews, the facility failed to develop and implement a policy or procedure for cleaning donated clothes/shoes for 2 out of 2 clothes donations storage cabinets to prevent the potential spread of infections. Findings:	A 748		

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A 748	Continued From page 70 A tour of patient floors 1 and 2 was conducted on 10/16/2018 at 2:10 PM with staff # 19 and #20. Patient floors 1 and 2 had a locked plastic storage cabinet standing in the hallway. The storage cabinets were called "Care Closets". The storage cabinets were found to have donated men's, women's, and children's clothes in them. An interview was conducted with staff #20 on 10/16/2018 at 2:10 PM. Staff #20 stated, "All donated clothes and shoes are left in my office and then given to the Program Managers to get washed. Once they are washed they are returned to my office to be placed in the Care Closet. We do not have a specific way to make sure they are cleaned and kept separate from any new donations. This is a program so there is no need for a policy." Staff #19 and #20 confirmed there was no policy on cleaning and monitoring the donated clothing	A 748		
A 800	CRITERIA FOR DISCHARGE EVALUATIONS CFR(s): 482.43(a) The hospital must identify at an early stage of hospitalization all patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning. This STANDARD is not met as evidenced by: Based on review of documentation and interviews, the facility failed to identify hospitalized patients who would likely suffer re-admissions for inadequate discharge planning. Patient #38 and #39 had multiple re-admissions for the same diagnosis. The discharge plans did not address anticipated problems after discharge.	A 800		

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A 800	Continued From page 71 Findings: Review of medical records of Patient #38 revealed, six admissions from 2/15/18 through 6/9/18 and Patient #39 had five admissions 4/10/17-10/9/17. In an interview with staff #20, director of social services, on the afternoon of 10/17/18 at the facility. Staff #20 said, previously they did not have a functioning discharge procedure. Staff #20 said, staff changes were made and new forms have been created. Staff is being trained on the correct discharge procedure. Staff #20 gave the surveyor copies of the forms the facility is currently using. The surveyor asked staff #20 when did the forms become effective as there was no revision or effective date on the forms. Staff #20 said, they are in the process of training the staff at this time. An interview was conducted on 10/17/18 at 4:40pm at the hospital with staff #30 (MHT) mental health tech concerning the discharge of patient #39. The surveyor asked staff #30, did she remember patient #39, staff #30 said yes, she was here several times; when it was time for her to be discharged she would become angry. It got so bad that staff would not tell her when it was time for her discharge. An interview was conducted with staff # 4, the risk manager, at 10:05 am on 10/17/18 at the facility. The surveyor asked staff # 4 about discharge	A 800		

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A 800	Continued From page 72 planning, staff #4 said that is handle by social services. Staff #4 said, he did a summary of events for patient #38 after being notified by Parkland the patient was taken by Dallas Police to Parkland on the eve of discharge from DBH. An interview was conducted with staff #2, CNO, on the morning of 10/17/18. Staff #2 was asked if he was aware of the multiple readmissions for patient #38 and #39. Staff #2 said, they are in the process of re-training for discharge planning.	A 800		
A 810	TIMELY DISCHARGE PLANNING EVALUATIONS CFR(s): 482.43(b)(5) The hospital personnel must complete the evaluation on a timely basis so that appropriate arrangements for post-hospital care are made before discharge, and to avoid unnecessary delays in discharge. This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to ensure discharge planning was completed timely to make arrangements before discharge as 6 of 6 (Patient #2, #3, #33, #41, #47, #48) medical records reviewed did not contain complete updated discharge planning in the comprehensive treatment plan which could result in possible inadequate aftercare for discharged patients. Findings were: Review of medical records for Patients #2, #33, #47, #48 revealed no documented active	A 810		

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A 810	Continued From page 73 discharge plans in the comprehensive treatment plans. Review of medical records for Patient #3 and #41 revealed no documentation of updated complete discharge plans in the master treatment plan until the date of discharge. An interview was conducted with the Chief Nursing Officer (CNO), Staff #2, on the morning of 10/18/2018. Staff #2 was asked if he could find specific discharge plans in the master treatment plan for Patients #2, #33, #47, and #48. Staff #2 stated "No. There are no specific discharge plans." Review of facility policy titled "Master Treatment Plan" with a revised date of "02-15-17" stated in part "F. The Master Treatment Plan includes: 1. Long Tern Goals (Discharge Criteria): a. Builds on the patient's strengths. b. Supports the transition to re-integration into the community when identified as a need. c. Barriers that may need to be considered include co-occurring illnesses, cognitive and communicative disorders, developmental disabilities, vision or hearing disabilities, physical disabilities, and social and environmental factors.	A 810		
A1081	STANDARD TAG FOR OUTPATIENT SERVICES CFR(s): 482.54 Standard-level Tag for §482.54 Condition of Participation: Outpatient	A1081		

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A1081	Continued From page 74 Services If the hospital provides outpatient services, the services must meet the needs of the patients in accordance with acceptable standards of practice. This STANDARD is not met as evidenced by: Based on review of record and interview, the outpatient department failed to follow the established policy of care for Multidisciplinary Treatment Planning for 2 out of 2 patients reviewed (Patient #24 and #25). Findings: Review of Patient #24's chart revealed the patient was attending the Partial Hospitalization Program (PHP). The patient had attended 13 program days without an update to the treatment plan. Review of Patient #25's chart revealed the patient was attending the Intensive Outpatient Program (IOP). The patient had first been admitted to the Partial Hospitalization Program. A treatment plan had been initiated upon entering the PHP on 9-14-2018. Patient should have attended 3 weeks of PHP for 15 program days and 1 full week of IOP for 3 program days. No update was made to the treatment plan based on program days or change in level of care from PHP to IOP. Review of Outpatient Policy #1200.13, Subject: Multidisciplinary Treatment Planning Meeting, Revised 2/28/2017 was as follows:	A1081		

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A1081	Continued From page 75 " .... C. The treatment plan will be updated within 10 program days or sooner if clinically indicated. The review will be documented on the Treatment Plan Review Form. ..." Interview was conducted with Staff #44. Staff #44 stated, she did not have a method to track program days for patients to ensure treatment plans were updated within the time-frame designated in the policy. Staff #44 stated, she did not know when these treatment plans had been due for update by the treatment team.	A1081		

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B 000	INITIAL COMMENTS Note: The CMS-2567 (Statement of deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation (s) will be referred to the Dallas Regional Office (RO) for referral to the office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An on-site unannounced full survey was conducted from 10/15/2018 through 10/19/2018 to determine the hospital's compliance with the Medicare Conditions of Participation set forth at 42 CFR Part 482. An entrance conference was held in a conference room with the administrative staff members. The purpose and process of the survey was explained and an opportunity was given for questions and discussion. An exit conference was held on 10/19/2018 with administrative staff members. The preliminary findings of the survey were explained. An opportunity was provided for the facility to provide evidence of compliance with those requirements for which non-compliance had been found during the survey.	B 000		
B 105	DEVELOPMENT OF ASSESSMENT/DIAGNOSTIC DATA CFR(s): 482.61(a)(1)	B 105		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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B 105	Continued From page 1 The identification data must include the patient's legal status. This STANDARD is not met as evidenced by: Based on review of record and interview, the facility failed to ensure State statutes for change of legal status were followed and documented. Findings included: Patient #21 had been admitted to the facility on 10-14-2018. During a review of Patient #21's chart on 10-16-2018, it was noted that the patient was brought to the facility under Apprehension by a Peace Officer Without Warrant (APOWW). Review of Texas Health and Safety Code was as follows: "HEALTH AND SAFETY CODE TITLE 7. MENTAL HEALTH AND INTELLECTUAL DISABILITY SUBTITLE C. TEXAS MENTAL HEALTH CODE CHAPTER 573. EMERGENCY DETENTION Sec. 573.021. PRELIMINARY EXAMINATION. (b) A person accepted for a preliminary examination may be detained in custody for not longer than 48 hours after the time the person is presented to the facility unless a written order for protective custody is obtained." Review of Patient #21's consents showed that his mother has signed a voluntary consent to treat on 10-14-2018 at 5:30 PM. The physician orders for admission (signed after the mother's consent) listed the legal status as involuntary.	B 105		

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B 105	Continued From page 2 Review of Texas Administrative Code, Title 25 Health Services, Part 1 Department of State Health Services, Chapter 133 Hospital Licensing, 411.465(2)(A)-(B) Care & Treatment: Involuntary to Voluntary was as follows: "A hospital may provide inpatient mental health treatment to an involuntary patient after the patient is eligible for discharge as described in §411.485 of this title (relating to Discharge of an Involuntary Patient), if prior to the provision of such treatment: (2) the patient's treating physician: (A) examines the patient; and (B) based on that examination, issues an order for voluntary inpatient mental health treatment that meets the requirements of §411.461(g) of this title (relating to Voluntary Admission)." No physician order for voluntary inpatient mental health treatment was found in Patient #21's chart. Interview was conducted with Staff #20. When asked about the physician order for involuntary legal status, the expiring APOWW, and no order to apply for court commitment, Staff #20 stated it was acceptable for the parent to sign the patient in as voluntary. Staff #20 stated they never get an order to change the patient's legal status. Staff #20 stated she was not aware of the State requirement to have a physician's order to change the patient's legal status and they never obtained an order for any of the patients who were converting from involuntary legal status to voluntary legal status.	B 105		
B 125	TREATMENT PLAN	B 125		

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B 125	Continued From page 3 CFR(s): 482.61(c)(2) The treatment received by the patient must be documented in such a way to assure that all active therapeutic efforts are included. This STANDARD is not met as evidenced by: Based on observation, review of records and interview, the facility failed to: A.) document active therapeutic efforts and treatment for patients as Patient #33 received emergency medication without documentation of prior de-escalation interventions by staff. Findings were: Review of the medical record on the morning of 10/18/18 revealed, Patient #33 was a 12-year-old boy, admitted to the facility on 09/21/2018 with an admitting diagnosis of Disruptive Mood Dysregulation Disorder (Adolescent). The patient was a current inpatient on Unit 5 at the time of the survey. A video observed in the office of the Director of Risk Management, Quality Assurance Performance Improvement, Staff #4, on the afternoon of 10/18/18 revealed the absence of any staff redirection of patients on Unit 7 teen boy's unit. The video revealed a couple of boys intermittently scuffling with each other while they were seated together in the open area of the unit watching cartoons. While watching the video, none of the facility staff walked over to where the boys sat to redirect or separate them.	B 125		

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Review of a "Daily nursing Assessment" dated 9/27/18 that read in part, "1720 Patient alert, oriented X3, very hyperactive, easily irritated. Acting out, running up and down the unit. Refused to follow unit instruction. Send to his room for time out continuous re-directing but still pt didn't want to follow instruction." At 1820 - Dr. _____ ordered emergency medications, Haldol 5mg/IM (in muscle), Ativan 1 mg/IM, and Benadryl 25mg/IM for agitation - and administered to the patient." The nurse narrative also stated, "1900 - Patient in his bed sleep and no distress observed. Will continue to monitor q15 mins for safety." The review revealed there was no restraint and seclusion package initiated. There were no documented vital signs for 09/27/18 after the administration of the emergency medication injection.

Review of the "Medication Administration Record" dated 09/27/2018 read in part, "Haldol 5mg/IM, Benadryl 25mg/IM, Ativan 1 mg/IM] X1 for agitation" was given at "1825."

Review of the "Patient Observation Rounds" dated 9/27/18 documented that from 1715 - 1815, Patient #33 was in the dayroom interacting with peers; 1830, he was in dayroom watching TV; 1845, he was in the dayroom lying down; 1900-1945, he was in the dayroom and appears sleeping; 2000-2345, Patient #33 was in his room and appears sleeping.

An interview was conducted with the Director of

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Risk Management, Quality Assurance Performance Improvement (QAPI), Staff #4, on the afternoon of 10/18/18 at approximately 4:30 pm after the surveyors watched the video of activity on Unit 7 on 09/27/18. When Staff #4 was asked if he saw any behaviors that posed a danger to self or others shown by Patient #33 that warranted the administration of Haldol 5mg/IM, Benadryl 25mg/IM, Ativan 1 mg/IM medication for agitation. Staff #4 stated, "I didn't see any agitation that warranted the shot." When Staff #4 was asked if he saw any staff interventions to talk with Patient #33 prior to the administration of the injection Staff #4 stated "No."

An interview was conducted with a Charge RN, Staff #34, on the morning of 10/19/18 at approximately 8:30 am in the hospital conference room. After Staff #34 reviewed her nursing notes dated 09/27/18 in the medical record of Patient #33. She was asked if she could explain why the12 year old patient was medicated with Haldol 5mg, Benadryl 25mg, and Ativan 1 mg. Staff #34 stated, the patient was running around the unit and would not settle down. Staff #34 stated, "I tried to talk to the baby. We've told him to sit down. Before we administer this medication we will try to talk with them. We call our male figures to talk with them. Sometimes we take them to seclusion and we just give them a time out." When Staff #34 was asked if staff monitored patients while they are in a time out in seclusion, Staff #34 stated, "We have somebody there to watch them. We will call a float MHT to come help." After Staff #34 reviewed the "Patient Observation Rounds" dated 9/27/18 that was completed by the unit MHTs, she was asked if she saw any documentation that Patient #33 had

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B 125	Continued From page 6 been agitated, running, or yelling. Staff #34 stated "I don't see it." When Staff #34 was informed that the surveyors had watched a video of Patient #33's behavior on the unit prior to the administration of the medications and that the surveyors observed him sitting in a chair watching cartoons, Staff #34 stated, "The baby was running around and wouldn't listen to us is all I know." Staff #34 was asked what was the nursing policy for monitoring patient after emergency IM medications are administered. Staff #34 stated, "We check the vital signs 30 minutes after giving the meds."	B 125		
B 133	DISCHARGE PLANNING CFR(s): 482.61(e) The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization. This STANDARD is not met as evidenced by: Based on review of documentation and interviews, the facility failed to identify hospitalized patients who would likely suffer re-admissions for inadequate discharge planning. Patient #38 and #39 had multiple re-admissions for the same diagnosis. The discharge plans did not address anticipated problems after discharge. Findings:	B 133		

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Review of medical records revealed patient #38 had six admissions from 2/15/18 through 6/9/18 and Patient #39 had five admissions 4/10/17-10/9/17.

In an interview with staff #20, director of social services, on the afternoon of 10/17/18 at the facility, Staff #20 said, previously they did not have a functioning discharge procedure. Staff #20 said, staff changes were made and new forms have been created. Staff is being trained on the correct discharge procedure. Staff #20 gave the surveyor copies of the forms the facility is currently using. The surveyor asked staff #20 when did the forms become effective as there was no revision or effective date on the forms. Staff #20 said they are in the process of training the staff at this time.

An interview was conducted on 10/17/18 at 4:40pm at the hospital with staff #30 (MHT) mental health tech concerning the discharge of patient #39. The surveyor asked staff #30 did she remember patient #39, staff #30 said yes, she was here several times; when it was time for her to be discharged, she would become angry. It got so bad that staff would not tell her when it was time for her discharge.

An interview was conducted with staff # 4, the risk manager, at 10:05 am, on 10/17/18 at the facility. The surveyor asked staff # 4 about discharge planning, staff #4 said that is handle by social services. Staff #4 said, he did a summary of events for patient #38 after being notified by Parkland the patient was taken by Dallas Police

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B 133	Continued From page 8 to Parkland on the eve of discharge from DBH. An interview was conducted with staff #2 CNO on the morning of 10/17/18. Staff #2 was asked if he was aware of the multiple readmissions for patient #38 and #39. Staff #2 said they are in the process of re-training for discharge planning.	B 133		
B 139	PERSONNEL CFR(s): 482.62(a)(3) The hospital must employ or undertake to provide adequate numbers of qualified professional, technical, and consultative personnel to provide active treatment measures. This STANDARD is not met as evidenced by: Based on review of record, observation, and interview, the facility failed to provide adequate staffing to ensure children and adolescents could be taken outside or to the gym for physical activity in order to de-escalate behavioral problems when they arose. Findings: An observations of video surveillance on the children's unit was made in Staff #4's office. During the observation review, Patient #33 was observed to be rough-housing with a boy sitting next to him in the day room. All of the children were sitting in the dayroom and a television set was observed to be on. No staff were observed to break up the interaction between the two boys. No staff were observed to be playing games with	B 139		

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or directing any activities with any of the children. One staff member was observed standing at a counter and another was sitting at a desk in the hallway. Other staff members were observed behind the counter of the nursing station. After the boys had calmed down and were no longer rough-housing, a staff member was observed escorting Patient #33 out of camera view. The patient's chart reflected he had received an injection at that time for emergency behaviors (behaviors that are deemed a danger to self or others). The video showed him sitting, calmly in his chair at the time he was escorted away to receive the shot.

Staff #4 was questioned about the interactions observed. When asked why the boys had not been taken to the gym to burn off the excess energy they seemed to have been displaying in the video, Staff #4 responded that the hospital didn't have the staff to take kids to the gym whenever the children wanted to go. He stated, it would take two Mental Health Techs or staff members away from the unit to escort patients to the gym. When asked why the hospital wouldn't take them if it would benefit the children and keep them from being medicated, Staff #4 repeated that they didn't have the extra staff. He explained that other children would see the first child rewarded for acting out and then all of the children would act out so they could go to the gym.

An interview was conducted with a Charge RN Staff #34 on 10/19/18, at approximately 8:30 am, in the hospital conference room. When Staff #34 was asked if the nursing units had enough staff to

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B 139	Continued From page 10 provide care to the patients. Staff #34 stated, "If we had enough staff, we can do more for the patients." Staff #34 stated that after 3:00 pm is when trouble starts because the boys have activities in the morning. When Staff #34 was asked how often are the boys on her unit permitted to go to the gym. Staff #34 stated, "We have to take turns in the gym. After dinner we can sometime take them to the gym, maybe every other day. When they go to the gym, it's my tech that have to take them to the gym. They have to go with 2 staff."	B 139		
B 150	NURSING SERVICES CFR(s): 482.62(d)(2) There must be adequate numbers of registered nurses, licensed practical nurses, and mental health workers to provide the nursing care necessary under each patient's active treatment program. This STANDARD is not met as evidenced by: Based on observation, review of records, and interview, the facility failed to ensure an adequate number of staff to provide care to patients to meet their needs. Findings: Observation of the patient units during the facility tour on the afternoon of 10/15/18 revealed the staff bathrooms were in the break rooms that were located off the unit in a hallway between units. The surveyor observed that the only way	B 150		

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for a Mental Health Technician (MHT) to contact the RN who is on break in the case of an emergency was to leave the locked patient unit and enter the locked break unit which leaves the patient unit without any available staff.

An interview was conducted with the Chief Nursing Officer (CNO) Staff #2 on 10/17/18, at approximately 3:10pm, in the facility conference room. When Staff #2 was asked if the current hospital staffing grid was developed according to best practices standards that will ensure that the needs of patients are met, he stated "I can't say truthfully that they were. They were established and determined as the one used before I got here. We sometimes give Units 1 and 2 an alternate nurse. The Nurse Advisory Committee approved the staffing and the float nurse and float tech were what the committee requested. In one of our town hall meetings the staff stated that 1 Mental Health Technician (MHT) was not enough so we now try to give 2 MHTs when possible." Staff #2 was asked if he thought that 1 MHT to 15-16 patients on the 11-7 shift was a safe staff to patient ratio and if this ratio took into consideration patients acuity and number of patients on suicide precautions as well as other duties the MHT has to complete during that shift. Staff #2 stated, "The patients on those units usually sleep all night. If they need extra staff we use the float MHT to help out." Staff #2 was asked if the facility always had a float MHT and RN available to help out on units. Staff #2 stated that if an assigned staff calls in and they can't get a PRN staff to fill the shift then the hospital assigns the float nurse and/or MHT to staff the unit.

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An interview was conducted with a House Supervisor RN Staff #33 on 10/18/18, at approximately 11:45 am, in a facility meeting room. When Staff #33 was asked how are unit nurses relieved for lunch breaks, he stated "We have a float nurse to cover lunches." Staff #33 stated that he will sometime help sit on units."

An interview was conducted with a Charge RN Staff #34 on 10/19/18, at approximately 8:40 am, in the hospital conference room. When Staff #34 was asked who relieved her for lunch breaks she stated, "We have a float nurse to relieve me. When we are short staffed we don't have someone to relieve me. I can't leave when we are short I don't clock out to eat my lunch." Staff #34 stated that when she goes to the bathroom, the float RN does not cover the unit for her because she is only off the unit for a short time."

Review of the facility policy titled "Staffing Plan, Policy #200.64, Revised: 09-03-2016" read in part, "To establish the number and qualifications of staff required to provide direct patient care.

Procedure: A core staffing level is determined for each unit consisting of registered nurses, mental health technicians, social workers, and therapists." The policy also states, "The established staffing grid is utilized for core staffing, with adjustments made for acuity/activity.

Changes in staffing needs during the shift are evaluated by the Nurse in Charge and

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B 150	Continued From page 13 communicated to the CNO/House Supervisor. The CNO/House Supervisor then utilizes existing in house staff or the PRN pool to meet the identified staffing needs as appropriate."	B 150		
B 152	SOCIAL SERVICES CFR(s): 482.62(f) There must be a director of social services who monitors and evaluates the quality and appropriateness of social services furnished. This STANDARD is not met as evidenced by: Based on review of records and interview, Staff #20 failed to ensure appropriately credentialed staff finalized the psychosocial assessment conducted upon patient admission. Review of Patient #21's chart for the 9-3-2018 admission showed that the psychosocial assessment was conducted and signed by a Licensed Professional Counselor not by a Licensed Social worker. Review of Patient #22's chart for the 11-15-17 admission showed that the psychosocial assessment was conducted and signed by a Licensed Marriage and Family Therapist, not by a Licensed Master Social Worker. An interview was conducted with Staff #20. Staff #20 stated that a countersignature was not required unless the person conducting the assessment was a student intern.	B 152		

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B 152	Continued From page 14 The Texas Administrative Code requirements were reviewed with Staff #20. Staff #20 stated, she had not been aware of the requirement. Review of Texas Administrative Code, Title 25 Health Services, Part 1 Department of State Health Services, Chapter 133 Hospital Licensing, 411.474(d)(2) Care & Treatment: Social Services was as follows: "(d) Assessment. (2) If a licensed social worker, a licensed professional counselor, a licensed psychologist, a psychological associate, or a licensed marriage and family therapist conducts the social services assessment, the results of the assessment shall be signed by the licensed master social worker evidencing approval of such results."	B 152		

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E 000	Initial Comments Note: The CMS-2567 (Statement of deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation (s) will be referred to the Dallas Regional Office (RO) for referral to the office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. An on-site unannounced full survey was conducted from 10/15/2018 through 10/19/2018 to determine the hospital's compliance with the Emergency Preparedness Medicare Conditions of Participation. An entrance conference was held in a conference room with the Administrative staff members. The purpose and process of the survey was explained and an opportunity was given for questions and discussion. An exit conference was held on 10/19/2018 with administrative staff members. The preliminary findings of the survey were explained. An opportunity was provided for the facility to provide evidence of compliance with those requirements for which non-compliance had been found during the survey.	E 000		
E 039	EP Testing Requirements CFR(s): 482.15(d)(2)	E 039		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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E 039	Continued From page 1 (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.	E 039		

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E 039	Continued From page 2 *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This STANDARD is not met as evidenced by: Based on review of documentation and interviews, the facility failed to have discussions for emergency preparedness. These discussions allows the facility to assess their plans for gaps, and opportunities to better understand their plan. Findings: No evidence was given to the surveyor verifying the facility had discussions for emergency preparedness. In an interview with staff #14 at the facility on the morning of 10/17/18 staff # 14 said the facility had not had the discussion.	E 039		